

Virginia Department of Education
Interdepartmental Complaint Reporting Form

DIRECTIONS: This form is to be used by all facilities for whom the Virginia Department of Education (VDOE) is the lead licensing authority. Please note that time frames established herein are solely for the purpose of informing the VDOE of the complaint. Facilities must honor reporting requirements as outlined in the Code of Virginia for suspected abuse or neglect, and as specified in the Standards for Interdepartmental Regulation of Children's Residential Facilities, at 22 VAC 42-10 §950 and §960. Facilities must complete the following three items for all complaints: 1) Immediately upon knowledge of the complaint, place a telephone call to Reba O'Connor @ 804-786-9022 to initially report the complaint, 2) complete Sections A-D of this form and return it within 48 hours after the initial call was placed to VDOE and 3) forward the completed internal investigation with supporting documents to Reba O'Connor, VDOE, P.O. Box 2120 Richmond, Virginia 23218-2120 within 10 business days of the initial call placed to VDOE.

Section A.

Name of Facility where incident occurred

Printed name of person reporting

Position Title

() -
Telephone Number

Signature of person reporting

Date of Report

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Section B.

Date of Occurrence: ____/____/____ Time of occurrence: ____ a.m. ____ p.m.

Incident Type: Check all that apply.

Alleged abuse: ____physical ____ sexual ____ verbal Alleged: ____ neglect ____ exploitation

Student Injury: ____bruise ____cut ____abrasion ____other (specify)

Medical evaluation: ____y ____n Treatment received: ____Y ____N

Details: _____

____ Supervision ____ Behavior management ____ Peer to Peer
____ Other (specify) _____

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Section C.

Description of the Incident (include staffing and supervision on the date and time of the incident): _____

Actions Taken by facility: (Specify) _____

Students involved: (Use additional sheets as necessary)

Name	DOB	Areas of Disability
Name	DOB	Areas of Disability

Staff involved: List all staff members by name and position title.

Witnesses: ____ check here if facility is in the process of obtaining this information

Name	() -	am	pm
Name	telephone number	best time to contact	

Name	() -	am	pm
Name	telephone number	best time to contact	

Name	() -	am	pm
Name	telephone number	best time to contact	

Section D.

Notifications: Include the name of person to whom the report was made, date and time of the report and the name of the staff person making the report.

Parent/Guardian: _____ Date: ____ Time: ____ By: _____

Placing Agency: _____ Date: ____ Time: ____ By: _____

CORE Lead Agency: _____ Date: ____ Time: ____ By: _____

Police: _____ Date: ____ Time: ____ By: _____

DSS: CPS _____ APS _____ Date: ____ Time: ____ By: _____

** Office of Human Rights: _____ Date: ____ Time: ____ By: _____

** Note: Applicable only for those facilities whose license is also signed by DMRMRSAS

Section E. To be completed by the Department of Education Representative

Specialist to fax form back to facility after determination of acceptance is made.

Accepted as Interdepartmental complaint? yes no

Signature of specialist _____ date: _____

Section F. To be completed by the Department of Social Services CPS or APS

Worker to fax form back to facility after determination of acceptance is made

DSS accept as complaint? yes no

Signature of DSS worker _____ date: _____

10/03 VDOE/RDO